Appendix C

IDAHO CERTIFICATION VERIFICATION REQUEST

PAGE 1 OF THIS FORM MUST BE COMPLETED BY THE APPLICANT.

Authorization to release information to the IDAHO EMS BUREAU

NAME:_____
First Last M.I.

ALSO KNOWN AS: _____
Alias, Maiden or Nicknames

MAILING ADDRESS: _____
City State Zip

IDAHO EMS AGENCY OF PRIMARY AFFILIATION: _____

I hereby authorize the state of _____ EMS credentialing agency to furnish the information requested on Page 2 of this document.

_____ _____
Certification/License Number EMS Level

_____ _____
Social Security Number Date of Birth

The Idaho EMS Bureau thanks you for your timely response and participation in completing this form.

Applicant Signature	**Date**

Internal Use
R/O Date Recd_____
R/O Date Sent to C/O_____
C/O Date Request Sent _____
Date Returned _____
Date Evaluated _____
Applicant Notified _____

IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAHO E·M·S

Appendix C

APPLICANT NAME _____

APLLICANT DATE OF BIRTH_____ APPLICANT SS#_____

THIS FORM MUST BE COMPLETED BY THE STATE EMS CREDENTIALING AUTHORITY

1. STATUS OF CERTIFICATION/LICENSURE

EMS LEVEL: _____

CERTIFICATION / LICENSE #: _____

EXPIRATION DATE: _____

2. HAS YOUR STATE TAKEN ANY DISCIPLINARY ACTION AGAINST THIS PERSON RESULTING IN A SUSPENSION, PROBATION, REVOCATION OR DENIAL FOR EMS CERTIFICATION OR LICENSURE? ☐ **YES** ☐ **NO**

IF YES, PLEASE DESCRIBE (Use Attachment if needed) ;

_____
_____
_____
_____
_____
_____
_____

3. IS THIS INDIVIDUAL CURRENTLY UNDER INVESTIGATION BY YOUR AGENCY? ☐ **YES** ☐ **NO**

IF YES, UPON COMPLETION OF INVESTIGATION, PLEASE NOTIFY THE IDAHO EMS BUREAU OF THE OUTCOME AND ANY DISCIPLINARY ACTION.

I hereby certify that the above information is true and correct recorded by this office.

_____
Signature

_____
Name (print)

_____
Title

_____
Agency Name

_____
Date

State Board or Seal

Please fax Page 2 to 208-334-4015 or mail to:
Idaho EMS Bureau
590 W. Washington St.
Boise, ID 83702
Attn: Credentialing Manager

IDAHO DEPARTMENT OF HEALTH & WELFARE